SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Cardiac Myosin Inhibitors

Drug Requested: (select drug below)

❑ **Camzyos®** (mavacamten)	❑ **Myqorzo™** (aficamten)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity limit: 1 capsule or 1 tablet per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by a cardiologist

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- ❑ Member had an adequate echocardiogram or cardiovascular magnetic resonance imaging (CMR)
- ❑ Member has evidence of maximal left ventricular wall thickness that meets **ONE** of the following **(submit documentation)**:
  - ❑ Left ventricular wall thickness ≥ 15 mm
  - ❑ Left ventricular wall thickness ≥ 13 mm in the presence of positive genetic testing or family history of oHCM
- ❑ Member has New York Heart Association (NYHA) class II-III symptoms **(submit documentation)**
- ❑ Member has documented left ventricular ejection fraction (LVEF) ≥ 55%
- ❑ Member has documented left ventricular outflow track (LVOT) gradient of 50 mmHg or higher (at rest or with provocation/Valsalva)
- ❑ Member remains symptomatic despite a trial of **TWO** of the following, or the member is intolerant to all or unable to use any **(verified by chart notes or pharmacy paid claims; failure of medications must be after titration to a dose where symptom benefit is observed)**:
  - ❑ Non-vasodilating beta-blocker (e.g., atenolol, metoprolol, carvedilol, propranolol)
  - ❑ Non-dihydropyridine calcium channel blocker (e.g., verapamil or diltiazem)
  - ❑ Disopyramide (as add-on to beta-blocker or non-dihydropyridine calcium channel blocker)
  - ❑ Septal reduction therapy
- ❑ Member meets **BOTH** of the following:
  - ❑ No history of septal reduction therapy in the past six months
  - ❑ No current plans for septal reduction therapy
- ❑ Member will **NOT** use the requested drug together with moderate to strong CYP2C19 inhibitors/inducers and strong CYP3A4 inhibitors/inducers (Camzyos requests), or with rifampin (Myqorzo requests)
- ❑ Provider is enrolled in the requested drug's REMS program and will adhere to all REMS requirements including appropriate dose titration based on echocardiogram results and monitoring for drug interactions and adverse events
- ❑ Provider has submitted at least **ONE** of the following baseline assessments of the member's symptoms associated with oHCM or functional status:
  - ❑ Exercise capacity or duration as measured by standard treadmill exercise protocol
  - ❑ Kansas City Cardiomyopathy Questionnaire score
  - ❑ NYHA functional class

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Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member must have improvement in symptoms or functional status from baseline (or stabilization from last reauthorization) demonstrated by at least **ONE** of the following **(submit documentation of symptom and/or test result improvement from baseline)**:
  - ❑ Exercise capacity or duration as measured by standard treadmill exercise protocol
  - ❑ Kansas City Cardiomyopathy Questionnaire score
  - ❑ NYHA functional class
- ❑ Provider has submitted results of the member's most recent echocardiogram obtained after starting the requested medication (**NOTE**: REMS programs require echocardiograms every 3 or 6 months after reaching a stable dose, or more frequently during dose adjustments)
- ❑ Member's LVEF remains ≥ 50%

Medication being provided by a Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified throu.gh pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** ~~7/21/2022; 5/25/2023; 3/26/2026;~~ **7/23/2026**
REVISED/UPDATED/REFORMATTED: ~~8/7/2022; 10/4/2022; 6/15/2023, 4/16/2026;~~ **8/28/2026**